ILLINOIS PARTNERSHIP

Partnership Represents: **Citizens of Illinois**
State of Illinois
Insurance Industry

LONG TERM CARE INSURANCE REPORT

STANDARDS

The Long Term Care Insurance Partnership Task Force recommends the following standards apply to all Partnership policies offered for sale in Illinois.

Insurer Participation - The state agencies charged with implementing the Partnership project recommend that all insurers that meet established standards be allowed to participate.

Eligible Population - For purposes of the Long Term Care Insurance Partnership demonstration project, persons over the age of 18 years shall be eligible to purchase Partnership insurance policies. Individual insurance carriers may direct policies to all, or a selected subset, of this population.

Asset Protection - The Task Force recommends that Illinois adopt the dollar-for-dollar asset disregard utilized in Connecticut, Indiana, and California. This approach means that for every dollar of Partnership insurance benefits purchased, an individual can protect an equal amount of assets from Medicaid spend-down. For example, if a citizen with $50,000 in assets, excluding the home and household belongings, purchased a Partnership policy with $50,000 in benefits, the citizen would be able to protect all of his or her assets. The insurance policy would pay the first $50,000 of long term care expenses. When the insurance benefit was exhausted, the citizen would then be eligible for the state's Medicaid program without spending down his or her own assets. Essentially, the approach would allow the consumer to plan ahead and purchase insurance to meet his or her spend-down obligation. Whether paid by insurance or

directly from the individual's assets, the state Medicaid program would not be used to support long term care services until the spend-down requirements are met Thus, this recommendation, as required by the legislation, is budget neutral. The minimum insurance purchase is the amount necessary to cover one year of nursing home care (approximately $36,500 in 1993). Additional insurance can be purchased.

Insured Event - The Task Force determined that it is important that:

* All persons who purchase a Partnership policy should have equal access to benefits, regardless of which insurer is selected; and,

* Because of the special relationship between Medicaid eligibility and insurance benefits, persons receiving Partnership benefits should meet Medicaid level of need requirements.

A study conducted by the Task Force revealed considerable variation among insurance companies in the determination of benefit status, even when the stated criteria are very similar. Therefore, the Task Force recommends using the following Illinois Medicaid criteria to determine whether benefits under a Partnership policy qualify for an asset disregard for a qualified insured:

* Earning fifteen or more points on Part A of the Determination of Need (DON), at least ten of which may be earned on the Mini-Mental State Exam (MMSE).

It should be noted that these criteria expand the coverage for persons with dementing illnesses, since cognitive impairment is measured on the MMSE without regard to whether

it was caused by Alzheimer's Disease or other related disorders.

Covered Services - Policy benefits can be used to purchase Medicaid-eligible long term care services which include the following:

1. Long term care services available under Illinois' state Medicaid plan, including care in a licensed nursing facility, home health nursing and home health aide services provided by a licensed home health agency, and speech, occupational, and physical therapy and medical transportation;

2. Long term care services covered under the Medicaid home and community-based services waivers for the aged, the disabled, and

HIV/AIDS victims, including homemaker, chore-housekeeping, personal care attendant, adult day care, assistive equipment, home renovation, home-delivered meals, and emergency response systems offered by Medicaid approved providers as part of an individual assessment and plan of care developed by a case management agency approved by the Department on Aging and/or the Department of Rehabilitation Services; and

3. Other alternate services which are deemed by the state Medicaid agency as essential to prevent institutionalization and offered by appropriately licensed or approved providers.

To qualify for an asset disregard, home and community-based services and/or alternate services must be specified in a written individualized plan of care developed by a state designated case management agency. The plan of care must specify the type and frequency of all services required to maintain the individual in the community, the service providers, and the cost of services.

Case Management - Case management services must be provided by agencies designated by the Departments on Aging and/or Rehabilitation Services as meeting criteria established by the insurer. If two or more approved agencies offer case management services in the insured's area of residence, the insured may select the case management agency.

Assessment of need and the development/revision of the plan of care shall be provided without charge to the insured. Agencies shall be reimbursed by the state for the administration of the Determination of Need.

The insurer must reimburse the agencies for the development of the plan of care and any additional required policy-specific activities related to the determination of eligibility for benefits, as well as any subsequent revisions, as a result of changes in need.

If the insured elects to have the case management agency perform service monitoring and plan of care implementation and management, the costs of these services shall be part of the policy benefit and count towards the asset disregard.

Expense Incurred Policy - The Task Force recommends the Partnership policy be of the expense incurred type, so that the policy will pay the actual cost of covered services up to the maximum selected by the purchaser. This type of policy permits the consumer to stretch the coverage, based on the prudent purchase of services.

For example, if a consumer purchased a policy that paid up to $100/day for nursing home care, but was able to go to a nursing home which cost only $80/day, the "savings" of $20/day could be used to purchase an extra 100 days of nursing home care. Or, if the

consumer elected to purchase home care services which cost only $20/day, the benefits could be stretched to up to five years of care.

Inflation Protection - Over the past several years, the cost of nursing home care in Illinois has increased by an average of 6% a year. To assure the consumer's policy will retain purchasing power, the Task Force recommends that all Partnership policies include annual benefit level increases of 5% compounded annually. This increase would be applied to both the monthly maximum benefit and the total benefit. Thus, for the person who bought a policy today at age 60 with a benefit of $100/day, the policy would automatically increase so that, at age 80, when long term care might be needed, the benefit level would be $252/day. Companies may offer the option of a higher inflation factor.

Claims Arbitration - Because there is the possibility that the insurer might not agree with the case manager's determination of eligibility for benefits, the Task Force recommends that the state participate in claims arbitration. The Departments on Aging, Rehabilitation Services, Insurance, and Public Aid each have complaint resolution and appeal procedures that can be brought into play to resolve differences, thereby assuring uniform administration of the policies, without regard to insurer.

Agent Training - In recent years, there have been several articles about insurance agents who are not knowledgeable about long term care, but are selling long term care insurance policies to people who should not be buying a policy, or who are being persuaded to buy the wrong kind of long term care insurance. To address this problem of suitability, the Task Force recommends mandatory initial training of twelve hours on long term care and the Partnership policy. The state will develop the

content of the training, and the insurer may elect to offer the training, or to contract for the training of agents.

30-Day Free Look Period - The Task Force recommends that a purchaser be allowed a thirty-day free look period, with the right to cancel the policy and receive a full refund of the premium paid if not satisfied for any reason.

Reduction of Benefits - If the policy is about to lapse, the insurer must notify the policyholder of this fact and offer the option to reduce coverage to a lower benefit amount. However, this benefit offer, plus the amount of benefits used to date, cannot be less than the minimum benefit required of Partnership policies. Premiums for the reduced policy shall be based on the age of the policyholder at the time of issuance of the original Partnership policy.

Third Party Notification - The Task Force recommends that the insurer advise the policyholder of the right to appoint a third party to be notified if the policy is going to lapse. The insurer must obtain a signed statement from those who do not want a third-party designee. This third party may keep the policy from lapsing for those who are sick or become unable to manage their affairs.

Reinstatement - In addition, the Task Force recommends at least a 90-day reinstatement period for a policyholder whose policy has lapsed due to nonpayment of premiums, and who has a cognitive impairment, and who pays all unpaid and due premiums. The reinstated policy shall have the same benefits, terms, and premiums as the policy which lapsed.

Guaranteed Renewable - The insurer shall not cancel an individual's policy for any reason other than failure to pay the premiums.

Policy Upgrades - Since long term care policies may change dramatically in the next few years, the Task Force retains the option to modify standards. In the event this occurs, consumers shall be required to pay only for the cost of the new or upgraded benefit, and the cost shall be based on the age at time of initial purchase, not the age at the time of the change.

Readability - The Task Force recommends that Partnership policies be printed in no less than 10 point type and conform to Illinois Department of Insurance Readability Standards.

Consumer Information - The Task Force recommends that Partnership policies and insurer advertising for such policies contain the name, address and telephone number of the Illinois Department of Insurance so that consumers may obtain information about the insurer, agent, or policy. In addition, the state will prepare consumer information, explaining the policy and options available, and a self-assessment tool for use by potential purchasers in determining the suitability of the policy, based on their own resources and financial goals.

Denial of Coverage - The Task Force recommends that insurers be required to provide the name, address and telephone number of the Illinois Department of Insurance to consumers whose application for coverage is denied.

RECOMMENDATIONS

Policy Options - To give the consumer flexibility to meet individual needs within available resources, the Task Force recommends several policy options described as follows:

Maximum Daily Benefit - The average private pay cost of nursing home care in 1993

is estimated to be $100/day. Therefore, the Task Force recommends one option to cover the average cost of nursing home care. The minimum purchase would be $36,500, the amount equivalent to one year of nursing home care at the daily average rate of $100/day. However, some individuals may have resources to pay for at least some of the daily cost themselves, or may desire a lower cost policy. Therefore, the Task Force recommends a second option, based on a daily maximum of $75/day and a minimum purchase of $27,375.

Insurers typically offer home care benefits at one-half the daily maximum allowed for nursing home care. However, the experiences of the Departments on Aging and Rehabilitation Services in managing their respective home care programs indicate that because the service is usually intermittent through a month, the total monthly cost is less than one-half the cost of nursing home care. To permit consumers the flexibility needed for in-home services, the Task Force recommends that the minimum for home care services be no less than one-half the **monthly** maximum for nursing home care. For example, if the consumer purchased a policy with the $100/day option, the **maximum monthly payment** for home and community-based services would be $1550 (31 days * $50/day). At the $75/day option, the maximum monthly payment for home and community-based services would be $1162 (31 days * $37.50/day).

Because some individuals may want a higher home care benefit, the Task Force also recommends that insurers offer home care benefits at 75% and 100% of the nursing home benefit. That is, a purchaser would have the option, at a higher premium, of securing a monthly maximum home care benefit as high as $3,100.00/-month.

Amount of Coverage - The Task Force recommends the minimum purchase be limited to one year of coverage ($36,500 for the $100/-day option; $27,375 for the $75/day option). Additional coverage could also be purchased. This flexibility will permit the purchaser to select the total amount of benefits based on the amount of assets to be protected.

Elimination Period - The Task Force recommends a range of elimination period options, so consumers may elect higher "deductibles" in order to reduce premiums. In general, research shows that, for many individuals, Medicare will cover the first few days of long term care so that an elimination period of 30 days would not incur a large outlay for the individual. However, some persons may still want to make no initial outlay, while others may elect a much higher initial outlay in order to reduce premiums substantially. To maximize this flexibility, the Task Force recommends a range of options, allowing elimination periods of 0, 30, 60, and 90 days. At the average cost of $100/day, these options require the initial outlay of $0, $3000, $6000, or $9000 respectively, before the policy begins to pay benefits.

In order for the differences between home and community-based services (which are intermittent services) and nursing home care (which tends to be offered continuously on consecutive days) to be accommodated, the Task Force recommends the elimination period be specified in terms of dollars, rather than days of service. With this change, the elimination cost, or deductible for home and community-based benefits (at one-half the nursing home benefit) would be $0, $1500, $3000, or $4500.

Waiver of Premium - The Task Force recommends that the consumer have the option of purchasing a waiver of premium benefit. With this option, he or she would not be required to pay premiums while receiving insurance

benefits for nursing home care, home and community-based care, or both. Some consumers may elect to reduce premium costs by not purchasing the waiver of premium benefit for one or the other service or both, or may elect to increase premiums in order to reduce personal outlay at the time long term care is needed.

RESPONSES TO PUBLIC FORUMS COMMENTS

Each forum was divided about equally between a presentation of the Partnership project, including draft recommendations of the Task Force, and a discussion period in which questions were answered and comments and suggestions were solicited. The suggestions and concerns are summarized below. Following the completion of the Forums, the Task Force met to review the comments and to finalize the recommendations presented earlier. Many of the suggestions from individuals attending the Forums are included in the recommendations. Below, the Task Force responds to concerns which were not incorporated in the final recommendations.

Cost - As indicated in the responses to the survey, as well as discussion during the Forums, the major concern was the cost of the policies. Many of the attendees were over age 65, and data suggest these persons are the most likely to consider purchasing long term care policies. Most of the individuals under age 60, where the cost is lower, indicated they would consider buying a policy at a later date. One commenter suggested that the cost could be reduced by allowing a state income tax deduction for the amount of premiums paid.

The Task Force has been, since the start of the project, most concerned with developing a policy which would be competitively priced. To

accomplish this, the Task Force has kept to a minimum the mandatory standards, offering higher cost options for the consumer who desires greater coverage. While premium costs could not be computed until the policy standards were finalized, the Task Force has maintained a close working relationship with insurance companies to assure Partnership standards are not too costly.

Pre-existing Conditions - Many respondents and commenters expressed concern over underwriting, noting they had been rejected because of existing medical conditions. Some urged the state to require insurers to accept all applicants without regard for pre-existing conditions. One suggested the state establish a "risk pool." The Task Force discussed this concern at length, noting that the working disabled, as well as many older persons with chronic conditions are excluded, in spite of their ability at present to live independently without formal support systems. However, it was recognized that a requirement for insurance companies to accept high risk clients would have the effect of increasing the premium costs to all. Given the concern for premium costs (see above), the Task Force determined that the first effort should be focused on persons who seek to purchase a low cost policy well in advance of any need for long term care. Therefore, the Task Force has remained silent on underwriting standards, allowing each company to develop its own standards. However, the Task Force did include a required notice of the right to appeal if coverage is denied.

Medicaid Certified Facility - A general concern, most often expressed in the northern regions of the state, was the need to go to a Medicaid certified nursing home. Many pointed out that some of the desirable nursing homes do not accept Medicaid. Of course, if the state allowed the use of non-Medicaid certified but licensed nursing homes, the resident would be

required to move after the insurance benefits were exhausted. The Task Force was sensitive to the desire of many individuals to have maximum flexibility in the selection of a nursing facility, and to the known trauma of persons having to relocate from one facility to another. Finally, the Task Force decided to retain the requirement that Partnership services would be restricted to Medicaid approved facilities. In addition to the concern for relocation trauma, this decision was influenced by data suggesting that only 10% of the facilities in the state are not Medicaid certified and the availability of non-Partnership long term care insurance policies to those who are adamant about their desire to reside in a non-Medicaid certified facility.

Home Care Maximum Benefit - Many feel the home care benefit should be pegged at the same level as that for nursing home care. One commenter, an independent insurance agent, noted that many policies offer 80 - 100% home care benefits, and one company offers 150% (at no increase in premium), and urged the Task Force to not set standards below the market.

The Task Force noted that the increase in the home care benefit would very likely raise the cost of the insurance policies and so revised the recommendations to permit the individual to purchase a higher option for home care. This action allows those who value this option highly, and are able to pay the higher premiums, to select this option without imposing higher premiums on those who do not need or can not afford the option.

Personal Care Attendants - A few commenters wanted the flexibility to hire neighbors and family for home care services, noting that the cost would be less than if a home care agency were hired.

The Task Force notes that this option exists if the individual worker can qualify as a personal care attendant under existing Medicaid standards.

Assisted Living - It was noted that assisted living is not a Medicaid service, but that many people desire this option and the cost could be less than nursing home care.

The Task Force notes that the "alternate plan of care" provision would allow the consideration of assisted living.

Insurance Company Insolvency - Many expressed concern that the insurance company might go out of business, and the policyholder would lose his/her premiums and protection.

While this risk exists, Illinois has been more successful than many states in screening out companies that are financially unstable. The Task Force determined that the present safeguards are sufficient, and elected not to address this issue in the recommendations.

Non-Forfeiture - One organization suggested that the policy include non-forfeiture benefits.

While the National Association of Insurance Commissioners (NAIC) has recently adopted such a requirement for long term care policies, specific standards have not yet been developed. The Task Force therefore concluded that it is premature to mandate a non-forfeiture benefit for Partnership policies, but will re-evaluate the issue at a later date. In the interim, companies would be free to offer non-forfeiture benefits as an option.

Agent Training - One organization suggested that, in addition to the required twelve hours of initial training, agents should be required to take a minimum number of hours of continuing education each year to maintain a certain level of competency. A competency test was also suggested. Insurance agents are required

to complete continuing education courses for the lines of business they are licensed to sell. However, Illinois does not require competency testing after an agent passes the initial licensing examination. The Task Force therefore determined it would be inappropriate to impose such a requirement for only the Partnership policies.

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